that compensation should be maintained. A careful general examination of the patient is necessary to determine whether this is present or absent. Low blood-pressure is of importance as indicating the possible failure in the action of the heart. In pregnant patients whose compensation is failing and when a well-defined heart lesion is present a very strict hygiene should be maintained. The least sense of fatigue is to be avoided, and if the patient cannot take exercise she should have massage until outdoor exercise can be maintained. Blood-pressure readings are of considerable value in determining the condition of the patient. Offending tonsils or teeth should be removed and the pregnant condition of the patient is no contra-indication.

GYNECOLOGY

UNDER THE CHARGE OF

JOHN G. CLARK, M.D.,
PROFESSOR OF GYNECOLOGY IN THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA,

AND

FRANK B. BLOCK, M.D.,
ASSISTANT INSTRUCTOR IN GYNECOLOGY, MEDICAL SCHOOL, UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA.

Comparative Physiology of the Corpus Luteum.—In recent years some very interesting facts have been observed by veterinarians on the influence of the corpus luteum on sterility and abortion in the cow, and it has occurred to OCHSNER (*Illinois Med. Jour.*, 1919, xxxv, 225) that this data might be of great value in solving some of the similar problems in the human female. It has been observed, for instance, that if a false corpus luteum remains unabsorbed in either ovary of a cow she does not come in heat, a condition which corresponds to amenorrhea in woman, and so long as the cow does not come in heat she, of course, remains sterile. On the other hand, as soon as the false corpus luteum is absorbed normally or is expressed manually by the operating hand of the veterinarian the phenomenon known as heat develops within twenty-four hours. This observation has been made so many times by a sufficient number of highly trained, experienced veterinarians that in the minds of the veterinary fraternity it is no longer a debatable question. The author has had a number of patients with premature menopause who gave the history of having suddenly stopped menstruating because of a severe chilling during a menstrual period and who have never menstruated since, and another considerable number of patients who, following a severe chilling or illness during a menstrual period, menstruated only at intervals varying from several months to several years, who have had the distressing symptoms of artificial menopause, whom he today would laparotomize, carefully examine the ovaries of, and if an unabsorbed corpus luteum were found excise the same, with the hope of relieving their symptoms, reëstablishing meninadequate or when the cystoscopic findings are not typical of renal tuberculosis. Furthermore, they are of special value when the clinical findings are not suggestive of renal tuberculosis or of any involvement of the urinary tract, as may occur with a closed tuberculous pyonephrosis. The roentgenographic shadows are caused by the deposit of calcium in the tuberculous area and may assume a variety of forms. To one who has had considerable experience in roentgenographic interpretation such shadows will have characteristics that are usually recognized and may be differentiated from a stone shadow by (1) the variability in its density, as the shadow is irregularly concentrated in its different portions; (2) by a shadow of lesser density throughout than that usually observed with stone; and (3) by its irregular and indefinite outline. The calcareous area may, however, simulate the shadow of a renal stone in every particular, and it may be quite impossible to differentiate it without further clinical data. The same is true of renal stones that are occasionally seen of such consistency that the shadow will be fully as irregular and hazy in outline as a typical tuberculous shadow. It may be said, however, that approximately 75 per cent. of tuberculous renal shadows may be recognized as such in the roentgenogram.

Prolapse of Uterus in a Young Virgin.—To most practitioners the the subject of uterine prolapse probably calls to mind a middle-aged woman, who has had many children or very difficult labors, with severe lacerations of the pelvic floor. It may be of interest, therefore, to refresh our memory on this subject and recall that occasionally uterine prolapse occurs in a virgin usually after the age of thirty. The case reported by MOORHEAD (*Surgical Clinics of Chicago*, April, 1919, p. 407) is of unusual interest, in that it occurred in a virgin who was only eighteen years old. When she presented herself for treatment she gave the usual history of a swelling at the vulva which had been present for one year, aggravated by exertion, and which disappeared when she was recumbent. There was nothing in her history to indicate the cause of this condition aside from the fact that she had been forced to do very hard and laborious work since she was twelve years old. The prolapse was a complete one, the uterus extending two inches outside of the vaginal outlet, drawing the anterior vaginal wall with it, although the posterior wall was only slightly involved. In the treatment of this case the author performed a high amputation of the cervix, shortened the uterosacral ligaments by plication and shortened the round ligaments by the Gilliam technic. The usual explanation of these cases of prolapse of the uterus in virgins is that there is a congenital weakness of the uterine supporting structures, especially the uterosacral ligaments and the connective-tissue structures in the bases of the broad ligaments, frequently called the cardinal ligaments. Naturally these structures must give way before a prolapse can occur, but whether they are congenitally weak or are weakened by an unusual amount of strain, as the author believes to have been the case with his patient, is a point that will have to remain debatable.